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A MARKET-BASED SEQUENTIAL HEALTH CARE REFORM PLAN FOR MONTANA

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State of Montana
Health Care Authority
Report to the Governor
and Legislature

December 16, 1995

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HEALTH CARE REFORM PLAN

FOR MONTANA

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A MARKET-BASED SEQUENTIAL HEALTH CARE REFORM PLAN FOR MONTANA

I. INTRODUCTION

In 1993, a bipartisan effort in the legislature enacted and the governor signed into law Senate Bill 285, which established the Montana Health Care Authority. The statute charged the Authority with developing a comprehensive statewide health care reform strategy that would provide all Montanans with improved access to high quality, affordable health care. As part of its development process, SB 285 required the Authority to develop two alternative universal access plans: (1) a tax–financed single payer system and (2) a regulated multiple payer system. The legislation established a large number of criteria to be considered in the design of these plans and called upon the Authority to report its recommendations to the legislature by October 1, 1994. The legislature in turn is charged with deciding during the 1995 session which — if either — of the two plans is most appropriate for Montana.

The Authority completed the two alternative comprehensive reform plans by the October 1st deadline and submitted a five-volume report on its findings to the legislature and the governor. Volume I of this report contains the alternative universal access plans; Volume II provides additional supporting documents and reference materials related to those plans; Volume III contains the regional and statewide health care resource management plans, also required by SB 285; Volume IV contains materials related to the Authority's extensive public participation activities conducted during the past year; and Volume V contains the health insurer cost management plans, also required by the statute. As such, these five volumes comprise a comprehensive characterization of the components and costs of Montana's health care system.

In the process of completing these tasks, however, the Authority came to the conclusion that to enact comprehensive health care reform in Montana by October 1995, the timetable set by SB 285, would be both too expensive and too precipitous. The single payer alternative, for example, would require up to $1 billion per year in additional state government funds, while the regulated multiple payer approach would require approximately $130 million per year in new state dollars. Both of these amounts would obviously place a significant new burden on the state budget. At the same time, the Authority believes that many of the reform mechanisms called for in SB 285 are unproven or would not fit together well in actual practice. Thus, it believes that a more moderate and gradual approach to health care reform should be considered.

This conclusion fits well with the bulk of public opinion on the matter. In response to a scientific telephone survey conducted on behalf of the Authority in mid-July of 1994, 54.6 percent of the respondents expressed the opinion that Montana's health care system is in need of major improvements. But when asked whether these changes should be rapid or gradual, 74 percent opted for a gradual pace for reform.

The Authority essentially agrees with this approach. In addition, it believes that whenever possible, changes made to the state's health care system should strive to improve the health care market structure in order to promote expanded access, cost containment and improved quality through better competitive mechanisms.

This report then, is intended to offer the legislature and the governor a third alternative -- one that is moderate, market-based and sequential in nature. This alternative is intended to be responsive to public feedback and is designed to establish a solid foundation for making long-term improvements in Montana's health care system while assuring the continuation of high quality services. It is also designed to stimulate such changes without undue governmental control or influence.

The Authority continues to welcome and encourage feedback on the ideas contained in this document and will continue to work closely with interested citizens, the governor and the legislature in the upcoming months to see that meaningful and affordable health care reform is achieved in Montana.

II. WHY HEALTH CARE REFORM IN MONTANA?

In spite of the recent demise of national health care reform and Montanans' clear preference for a go-slow approach to reform at the state level, most (if not all) of the problems which made health care reform such a high priority of the governor and the legislature in 1993 have not yet been solved. They include the following (a more detailed discussion of health care problems in Montana is contained in Volume I of the universal access plans report):

1. **Cost inflation.** In spite of efforts by providers to hold the line on increases in fees and charges, health care spending in Montana continues to rise at approximately 9.5 percent per year, representing only a slight decline in the historical 15-year growth trend and continuing to run well ahead of the overall rate of inflation in Montana's economy, as well as the annual increase in total wages and salaries. Estimates developed by the Authority's consultants indicate that the state's total health care spending in 1994 will exceed $2.1 billion. It has also been estimated, based upon national projections adjusted to reflect historical Montana trends, that by the year 2000, annual health care spending in the state will climb to nearly $3.7 billion and by 2005, statewide spending under the current system is expected to reach $5.4 billion.

   If these health care spending figures are converted to a per capita basis, they show that per capita spending has increased considerably in past years and is expected to continue to rise in the foreseeable future. For example, from 1980 to 1992, per capita spending in Montana increased from $859 to $2,179 per year and is projected to increase to $4,221 by the year 2000 and to $6,075 by the year 2005.

   Perhaps the most unsettling aspect of these increases is that they far outstrip the ability of Montana families to pay for them. For example, from 1980 to 1990, when health care spending was estimated to have grown by 143 percent, total wages and salaries for Montana workers increased by only 52 percent. Thus, in 1980 the average Montana family spent 7.5 percent of their income on health–related expenditures; by 1991, the average health–related payment made by a Montana family had increased to 10.8 percent of their annual income.

   The burden of rising health care costs impacts state government as well as Montana families and businesses. The state's share of the costs of the Medicaid program

during the 1995-1997 biennium is projected to increase by approximately $51 million, thereby further impairing Montana's ability to finance other needed services such as education, infrastructure development and public safety.

The factors primarily responsible for these cost increases include price and fee increases by providers and suppliers, demographic changes involving both population increases in general and an aging population in particular and increased utilization of services and resources (which includes the application of new technologies as well), both in terms of numbers and intensity.

Clearly, health care cost inflation continues to be a major problem for individuals, families and state government in Montana.

2. **Access to coverage.** According to a report recently released by the U.S. Bureau of the Census, the number of people in Montana without any health insurance coverage totaled 15.3 percent in 1993, up from 9.4 percent in 1992. A closer look at the characteristics of uninsured Montanans reveals that:

- The vast majority of uninsured Montanans have either been employed full- or part-time during the past year or are dependents of such workers.

- Despite this link to the work force, the majority of the uninsured are low income individuals and families -- the working poor.

- Approximately one-fourth of the state's uninsured are children and young adults.

- A significant number of Montanans are "underinsured", that is they have coverage that does not provide them with adequate protection against a catastrophic illness or with financial access to primary and preventive services.

3. **Access to Services.** Because of the significant provider shortages that exist throughout the state, many Montanans do not have reasonable access to health care services.

- The problems with the state's health care delivery system are reflected in the fact that over half of Montana's counties are officially designated as Medically Underserved Areas (MUAs), a federally developed measure identifying areas that are critically underserved.

- In addition, 41 of the state's 56 counties are designated as Health Professional Shortage Areas (HPSAs), another federally established designation given to areas suffering from serious health personnel shortages, particularly of primary care physicians.

4. **Market characteristics.** The health care market tends not to function like other markets in the U.S. economy. In fact, because of the lack of readily available information regarding prices, fees and charges, consumers typically find it very difficult to access the health care market as they would other markets they participate in. In addition, reimbursement practices in the health care market generally provide much more generous payment for acute care than for preventive and primary care and tend to favor institutional care over less expensive in–home or other alternate site care. These characteristics tend to produce a health care market where competition does not always result in efficiency or high quality.

5. **Information.** A lack of consistent and timely data about the costs, utilization and quality of Montana's health care system means that providers and consumers alike cannot obtain relevant and up–to–date information regarding the efficiency and effectiveness of services.

- As in many other states, there is no unified source of health care information and the information that is available is typically 12 to 18 months out–of–date, thereby reducing the ability of consumers to access the system in the most efficient and effective ways possible.

- It has the added negative effect of making the system much less sensitive to normal economic market forces which serve in other market areas to control prices and utilization.

The above problems have been growing in severity for the past 15 years or so and were largely responsible for the enactment of SB 285 as a comprehensive effort to make substantial improvements to the health care system in Montana. And regardless of whether the approach to health care reform is ultimately comprehensive or incremental in nature, these problems will still require resolution if the fundamental goals of SB 285 are to be accomplished.

III. GUIDING PRINCIPLES FOR HEALTH CARE REFORM

Policy Goals

As stated in its universal access plans report, the Montana Health Care Authority believes that the overriding goal of the state of Montana's health–related policies should be to improve the health status of its population. In pursuit of this goal, SB 285 specifies that the policy of the state of Montana is to ensure that all residents have access to quality health care services at costs that are affordable. The Authority believes that this should continue to be the state's primary health care policy goal.

More specifically, the Authority believes that efforts to legislate or otherwise encourage health care reform under its market-based sequential strategy should address the following goals:

- **Continue to expand access for Montana citizens to both health care coverage and services.**

- **Contain the growth in health care spending so that it eventually is commensurate with the overall rate of inflation in the Montana economy.**

- **Improve the quality of health care services in Montana for all Montanans.**

Guiding Principles

In developing its market-based sequential health care reform strategy, the Authority has placed special emphasis on the following guiding principles and recommends that the legislature do the same:

1. **Montanans should have access to the health care services they need without having to incur excessive out-of-pocket expenses.**

2. **Montana's health care system should insure that care is delivered in the most effective and efficient manner possible.**

3. Health promotion and preventive health services should play a central role in the system.

4. The patient-provider relationship should be a fundamental component of Montana's health care system.

5. Individuals should be encouraged to play a significant role in determining their health and in using the health care system appropriately.

6. Accurate and timely health care information should play a significant role in guiding health care resource allocation, utilization, and quality of care decisions, both by consumers and providers.

7. Wherever possible, market-based approaches should be relied on to contain the growth in health care spending. In particular, both the appearance and reality of significant government control or regulation of Montana's health care system should be avoided unless and until it is clearly demonstrated that the principal goals of expanded access, cost containment and improved quality cannot be achieved without more government involvement.

8. The process of health care reform in Montana should be carried out gradually and sequentially to ensure that any negative impacts of the state's reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

IV. MARKET-BASED SEQUENTIAL HEALTH CARE REFORM IN MONTANA

Overview

As an alternative to comprehensive health care reform through either a single payer or a regulated multiple payer approach, the Authority recommends a market-based sequential approach based on the guiding principles listed above. This approach is intended to effectively initiate a reform process in Montana that involves a minimum of new state dollars, that is implemented gradually and that proceeds logically from one step to the next. As such, it encompasses:

1. **Expanded access to health care services.**

2. **Health insurance market reforms.**

3. **A market-based cost containment strategy.**

4. **Selected health care system infrastructure and delivery system improvements.**

Expanded Access to Health Care Coverage and Services

The Health Care Authority believes that the state should continue to pursue the goal of providing affordable health insurance coverage for all Montanans, but that it is not realistic to expect that it can be accomplished overnight. Rather, the Authority recommends that a sequential approach be adopted which will result in a gradual expansion of access to health insurance for those Montanans who typically do not have such coverage. In addition, the Authority believes that expanded access to services, especially in rural areas, must go hand-in-hand with expanded access to coverage. Therefore, it recommends that the following steps be taken in these crucial areas:

1. **Expand Medicaid eligibility for pregnant mothers and low income children.**

   A number of states have adopted the approach of increasing Medicaid eligibility to as high as 200 percent of the poverty level as a relatively low-cost way of increasing access to health insurance coverage. There are several reasons for this:

   - This population group is least likely to have health insurance coverage and

tends to be the most vulnerable to the negative impacts of having to pay excessive health care costs.

- Providing coverage to the age group between zero and six-years-old constitutes an excellent investment because many problems can be treated during that time which, if left untreated, can end up costing the tax-payers much more as these children grow older.

- The federal government will pay (in Montana's case) about 70 percent of the costs of such services.

A second approach to dealing with this problem that has been adopted in a handful of states involves the Caring Program for Children Foundation, administered by Blue Cross and Blue Shield of Montana. This is a private sector initiative which is currently funded by charitable contributions matched by funding from Blue Cross and Blue Shield. It provides a limited package of preventive and primary health care benefits to uninsured children up to age 18 who are members of families with incomes at or below 150 percent of the federal poverty level and are above Medicaid eligibility requirements. Pregnant mothers are not presently covered under the program.

Caring Program benefits are provided with no cost sharing, no health restrictions and no pre-existing conditions. BC/BS administers the program at no charge and physicians, hospitals and other health care providers have agreed to accept Caring Program reimbursement as payment in full.

SRS is currently investigating the possibility of the state providing direct funding to the Caring Program to enable it to provide more coverage to more children, an approach that has been used in other states which also have Caring Programs. This state funding, which may require federal waiver approval, would be used to help off–set costs of limited care for children between the Medicaid threshold for eligibility and 150 percent of the federal poverty definition. Thus, children between the ages of 0 and 6 who are between 133 and 150 percent of poverty would qualify for program services, as would children between the ages of 7 and 11 who are between 100 and 150 percent of the poverty level and children 12 through 18 who are between 52 and 150 percent of the poverty level.

The Authority believes that high priority should be given to expanding the eligibility threshold for pregnant mothers and children in Montana in order to improve their health status and ultimately achieve cost savings and therefore recommends that:

- **Medicaid eligibility in Montana should be expanded to 200 percent of poverty for pregnant mothers and children aged 0 through 6; and**

- **The state should provide matching funds to the Caring Program for Children in order to provide coverage to children aged 7 through 18.**

2. **Provide support for the Family Practice Residency Program as a method of increasing access to primary care physicians, especially in rural areas.**

The Authority recognizes that many of Montana's health care access problems, especially in rural areas, cannot effectively be addressed without more primary care physicians. One effective means of increasing the number of primary care (or family practice) physicians in Montana will be the establishment and implementation of the new family practice residency program. This program is a private sector initiative designed to focus primarily on eastern Montana; it is supported with private contributions as well as funds appropriated by the 1993 legislature and is expected to be fully operational by July 1996. Six qualified medical students will be accepted annually into the three-year program. Since statistics suggest that some 70 percent of physicians select their practice site based upon the location of their residency program, the family practice residency program is expected to facilitate the recruitment and retention of family physicians for underserved areas in the state, especially in eastern Montana. In particular, placement of graduated Montana WAMI students in an eastern Montana residency program should eventually result in greater physician relocation efforts in rural or underserved sites in the state.

The Authority therefore supports the governor's recommendation of $200,000 in additional funding for the program during the 1997 biennium.

3. **Individuals without insurance coverage through their workplace and sole-proprietorships, partnerships and Subchapter S. corporations should be allowed tax deductibility for health insurance premiums equal to that of businesses.**

Currently, individuals whose employers do not provide health coverage and sole-proprietorship and partnership businesses and Subchapter S. corporations are not, unlike other businesses, allowed to deduct the full cost of health insurance premiums from either their federal or state income taxes. This is inequitable and creates a disincentive to obtaining health insurance coverage.

The Authority therefore recommends that individuals, sole-proprietorships, partnerships and Subchapter S. corporations should receive the same tax treatment as other businesses, with the anticipated result being to stimulate expanded health insurance coverage among these groups.

The Authority recognizes, however, that for this approach to have a significant impact, federal tax deductibility is also important. In lieu of federal action, however, the Authority believes that the state should take the lead in correcting this inequity.

If premiums for all currently purchased non-group health insurance were deducted at 100 percent for individuals and small businesses, the Authority estimates that the state general fund revenue loss would not exceed $7 million per year in 1993 dollars. This assumes that all those premiums, if deducted, would decrease tax liabilities for all filers taking advantage of the new deduction.

4. **Provide for mandatory employer insurance offering to employees.**

Another means of encouraging expanded health insurance coverage would be to make such coverage more readily available in the workplace. Approximately 85 percent of those who are without insurance coverage in Montana are part of the workforce. Currently, however, if an employer chooses not to provide a health benefit plan for his employees, the worker has no recourse but to either forego coverage or to locate it privately. The Authority believes that all employers in Montana should be required to at least offer insurance coverage to their employees. That is, while employers would not be required to pay for health care coverage for their workers, they would have to make arrangements to have health insurance premium contributions deducted from employees' payroll checks and forwarded to insurance carriers. The Authority believes that this approach would

significantly increase the numbers of workers who have coverage simply by making it easier for them to access such coverage.

Health Insurance Market Reforms

It has long been recognized in Montana and the nation that if the goal of affordable health insurance coverage for all citizens is to be achieved, changes have to be made in the way the health insurance market operates. Small group reforms are typically deemed necessary in order to promote the availability of health insurance to small employers regardless of a employees' health status, claims experience or occupational status and have usually included the following basic provisions:

- Guaranteed issue of coverage.
- Guaranteed renewability of coverage.
- Portability of coverage between jobs.
- Limitations on the use of pre-existing condition exclusions.
- Elimination of unfair rating systems which price health insurance out of reach for individual members of employer groups who are either less healthy or in job occupations which are considered a higher risk for injury.

In addition, small group reform statutes in other states usually provide for the development of two levels of benefit plans -- standard and basic -- as Montana does and stipulate that all insurers operating in the small group market must offer at least these two plans to all employer groups. These requirements are applied to all employer groups which range in size of from 1 to 100, depending on the state.

In the past several years, 43 states have enacted small group reforms in an effort to expand coverage and bring more equity to the system. Of those states, 88 percent have enacted guaranteed issue requirements, 95 percent provide for portability between jobs, 100 percent require guaranteed renewal of coverage, 91 percent set limits on pre-existing condition exclusions and 100 percent provide for community rating restrictions.

In Montana, Governor Stan Stephens' Health Care for Montanans task force recommended a slate of comprehensive insurance reforms to the 1993 legislature to include these features and to be "based on the National Association of Insurance Commissioners 'Small Employer Health Insurance Availability Model Act' for small employers with similar provisions extended to individual policies." These and related changes were incorporated into the Montana Small Employer Health Insurance Availability Act and enacted as a part of SB 285, with December 7, 1994, set as the implementation deadline for small group reforms.

The Authority believes that small group health insurance reform is an important first step toward the accomplishment of health insurance market reform in Montana. In fact, the Authority found overwhelming support for the objectives of small group reform by Montana citizens throughout the state. The Authority further believes it is important to have reforms which promote the availability of health insurance to the small group market because many of its features already are available to large employer groups. As a result, the employees of large firms typically enjoy better health coverage at costs lower than what is currently available to small employers. The option most often chosen by small employers is to not participate in any group coverage plans on behalf of their employees.

The Authority strongly believes that small group insurance market reform must be an essential part of even incremental health care reform and believes that the following market changes should be either retained or enacted:

1. **Health coverage should be available on a guaranteed basis. This means that no one could be denied coverage or be dropped by an insurer because they are in poor health.**

2. **Coverage should be portable, with persons not having to worry about losing their insurance if they change jobs.**

3. **Only a single 12-month exclusion of pre-existing conditions should be allowed. Once that exclusion period has passed, no one would be subject to another waiting period, even if they changed jobs, unless they failed to maintain continuous coverage.**

4. **Health care premiums should be set on a modified community-rated basis -- that is, the cost of coverage should be the same for everyone, regardless of their sex, occupation, or health status, except that different premiums could be established for different age groups. The transition to this approach should occur over a gradual time period so as to minimize dislocations in the market.**

5. **These changes should be applied to employer groups of 1 to 100, with individuals included on a risk-adjusted basis. (Group size should directly correlate to group size to be included in the Authority's purchasing pool recommendation, discussed below. If group size in the purchasing pool legislation is adjusted, the size of groups affected by small group reform should be similarly modified.)**

6. **All employer groups affected by these changes should be offered at least two standardized benefit plans -- one which establishes a minimum (or basic) level of coverage and a second which provides an average level of coverage.**

7. **In addition to the standard and basic benefit plans, consideration should be given to include a medical savings account type of plan as a third option. A high deductible major medical benefit coupled with the medical savings account option appears to have merit for eligible firms wishing to participate in small group reform but who believe that the current standard or basic benefit packages are not responsive to their particular needs.**

Market-based Cost Containment

If there is to be a commitment to providing insurance market reforms and expanded access to both health care coverage and services in Montana, it is critical that this coverage be affordable. This can best be accomplished through the development and implementation of an effective cost containment strategy.

SB 285 advocates a cost containment approach that places a substantial emphasis on government regulation. The Authority, on the other hand, prefers a much more market-oriented approach to controlling costs. In part, this is due to the lack of available comprehensive information on how the health care system operates in Montana, but it is also the result of a desire to see the health care system subjected to true market forces, which is not now the case. To implement this market-based approach to cost containment, the Authority recommends the following steps:

1. **Provide for the formation of a private, voluntary statewide health insurance purchasing pool.**

   The objective of a health insurance purchasing pool is to permit small employers and individuals to realize some of the advantages that large employers enjoy in purchasing health care coverage. Typically, purchasing pools do not assume risk but instead negotiate contracts with health plans already in the market and make those plans available to the people who participate in the pool. By negotiating for health coverage collectively, these small purchasers can command sufficient market share to induce health plans to be responsive to their particular needs and to pass on some of the economies of scale that result from centralization of marketing, enrollment and premium collection. In particular, administrative costs, which represent a large portion of the premium paid by small purchasers, should be substantially lowered. And competition among health plans seeking to capture more of this market should also improve the efficiency of health care delivery.

   The Authority believes that the establishment of one or more private, voluntary purchasing pools in Montana could make a significant contribution toward the goals of cost containment, expanded access and improved quality of care and therefore recommends that the legislature take those steps necessary to authorize the establishment one or more pools in the state. (A detailed discussion of purchasing pools is contained in an Authority report submitted to the legislature and governor on December 15, 1994.)

2. **Promote managed care and utilization review for both private insurance and Medicaid.**

   Managed care is an approach to health care service delivery that integrates financing and delivery of health care services to covered individuals by arrangement with selected

providers to furnish a comprehensive set of health care services. It has grown in popularity during the past several years in this country because it has consistently proven to be an effective market-based approach to controlling the growth of health care costs.

Managed care organizations can take a variety of forms, including health maintenance organizations (HMOs), preferred provider organizations (PPOs) and physician-hospital organizations (PHOs), among others. Regardless of the form, however, managed care organizations typically rely on one or more of the following strategies:

- Enrollees paying a set rate to a group of providers determined by the number of members, with incentives to the providers by keeping utilization down;

- Enrollees seeking care from providers who participate in the plan, or paying extra out of pocket if going outside of the plan;

- Enrollees having care coordinated through a primary care physician who in turn authorizes specialty care; and

- Utilization review where payment for care is contingent upon the care being deemed necessary by a group of peer health care professionals.

Until recently the market penetration of managed care organizations in Montana (unlike more populated areas) has been fairly small. In the past few years, however, two new managed care organizations have been certified, bringing the total of such plans to three. In addition, several other groups in such communities as Missoula, Helena and Havre are currently exploring the feasibility of establishing additional community-based managed care organizations.

The Authority supports the continued development of managed care in Montana, believing that such plans offer an effective, market-based approach to expanding coverage and containing health care costs. In particular, the Authority supports the current of efforts of the Medicaid program in SRS to develop a managed care approach along with the various community-based efforts.

In recommending that private insurance and Medicaid continue in their current efforts at developing managed care strategies, the Authority strongly believes that the utilization review components of managed care organizations should be operated in a manner that does not jeopardize the quality of patient care or unduly interfere with the doctor-patient relationship in attempting to achieve cost containment. Utilization review, as a monitoring device for appropriate utilization of care, functions best when an individual's care options are fully explored and the patient's primary caregiver has the opportunity to participate in the review process. Identification of treatment options and involvement of caregivers should enhance the quality of care received as well as maintain the freedom of choice afforded to the Montana health care consumer. While cost containment is the primary motivating factor in managed care, such a system should not foster decision making based on finances rather than patient care. In addition, the Authority believes that there should be full disclosure of any agreements between insurers and providers in managed care plans which would have the effect of arbitrarily limiting patient care or quality of service.

3. Support federal and state income tax deduction for those who establish medical savings accounts.

A medical savings account is typically defined as a tax-deferred account established by an employer or individual for two primary purposes:

1. To allow for payment of all aspects of an employee's or individual's yearly out-of-pocket medical and health care expenses incurred to a pre-determined limit; and

2. To allow for the accumulation of individual savings to pay for future medical and health care expenses.

Typically, MSAs are intended for use in conjunction with a high deductible catastrophic health insurance policy, where the MSA is used to cover the amount of the deductible and co-insurance. To date, the states of Arizona, Colorado, Idaho, Illinois, Michigan, Mississippi and Missouri have enacted medical savings account legislation as part of their health care reform and medical cost containment strategies.

The MSA concept is based upon three major assumptions regarding consumer behavior in the health care system:

1. MSAs encourage individual responsibility and self-restraint in decision-making about health care utilization by offering consumers a direct financial incentive to decrease their health care utilization by foregoing unnecessary medical treatment and to shop for the best value in cases in which treatment is deemed necessary. It is believed that consumers will become more cost-conscious if they pay their health expenditures out of their own pockets.

2. MSAs are believed to promote competition and control costs in all facets of the health care system. With MSAs, it is assumed that health care utilization and expenditures would decrease because consumers would be more frugal with their own money rather than having utilization and payment decisions made by a third party. Further, MSAs would spur competition by health care providers who would choose to lower their fees in an effort to compete for consumer dollars.

3. Individuals are allowed to accrue the unexpended funds in the MSAs to be used for future medical expenses, including the purchase of health insurance if the employee loses his or her job or payment for expenses related to long term care. This approach is expected to reinforce frugal shopping for health care services by consumers.

After conducting an extensive analysis of medical savings account programs enacted across the country, neither the Authority nor its consultants could find an example of a medical savings account program that is fully implemented and so were unable to determine if the above assumptions are valid. **However, the Authority believes that the MSA concept deserves a serious trial in Montana and therefore recommends enactment of legislation that includes the following features:**

- **Permits employers to establish medical savings accounts for their employees and permits individuals with their primary domicile in Montana to establish MSAs for themselves;**

- Limits the amount which may be contributed to the MSA to $3,000 per person annually;

- If an employer contributes less than the maximum allowed, permits the employee to contribute the difference;

- Allows for employees to establish their own accounts within the $3,000 annual limitation if an employer does not make the option available;

- Provides that employee contributions to a medical savings account be made on a pre-tax basis through payroll deductions and makes employer contributions to employee medical savings accounts a state tax deduction;

- Provides that medical expenses be reimbursed from a medical savings account only if incurred by the individual, spouse, or on behalf of a dependent as defined by tax codes;

- Provides that amounts withheld from an employee's wages for deposit into a medical savings account and interest earned on funds in the account are not to be included in the employee's taxable income for state tax purposes;

- Provides that the employee may transfer the account to a new employer if the employee changes jobs;

- Provides that funds may be withdrawn for non-medical purposes on the last business day of the MSA benefit year and that such withdrawals and the interest earned are subject to state income tax;

- **Provides that on all other days, non-medical withdrawals and interest earned on those funds, in addition to being subject to state income tax, are subject to a 10 percent penalty; and**

- **Provides that amounts that have accumulated in a medical savings account and amounts that have been withdrawn from the account to pay medical expenses are not to be taxed for state income tax purposes and that funds used for non-medical expenses are subject to state income tax.**

The Authority strongly believes that for this program to be effective, improved consumer information needs to be readily available, ideally from a comprehensive health care information data base. In addition, the Authority believes that, if enacted, the medical savings account program needs to be closely monitored to determine whether it proves to be cost effective and achieves the goals of encouraging individual responsibility and self-restraint and promoting competition and controlling costs.

4. **Support aggressive medical insurance fraud prosecution effort.**

Ten percent of the cost of insurance policies can be linked to fraud and abuse. This translates into $40 million to $50 million a year in Montana. Insurance companies pass along the cost of abuse to consumers and businesses either as higher premiums or reduced coverage. The majority of agents, carriers and consumer are honest and want the wrongdoers caught. In some cases, the insurance laws are vague or absent, making what is or is not legal unclear.

The Insurance Commissioner's office currently only has power to go after bad insurance agents and employs two investigators for that purpose. Through its deliberations on cost containment, the Authority has identified the need to broaden medical insurance fraud prosecution efforts to include the entire network of insurance fraud from the consumer who illegally files a claim, to the provider who bills for services not given, to the agent who misrepresents policies, to the insurance company that overlooks or encourages illegal practices or policies.

The Authority supports efforts to reduce fraud and abuse, including actions to clarify existing statutes to more clearly define fraud and abuse and to centralize these efforts in order to avoid duplication of efforts regarding Montana's workers' compensation, Medicare and Medicaid programs.

5. **Update regional and statewide health care resource management plans on a biennial basis; merge the state comprehensive health plan into resource management planning process.**

SB 285 required the Authority, in conjunction with its regional health care planning boards, to complete and annually update a health resource management plan designed to provide an inventory of existing health care resources and services which can be used periodically to identify gaps and duplications in existing levels of resources and services. These plans are to be completed on a regional and statewide basis. In addition, the legislation provides for the transfer of comprehensive health planning activities from the Department of Health and Environmental Sciences to the Authority by July 1, 1996.

The Authority believes that these two planning processes could be effectively merged into a single effort and carried out on a biennial (rather than an annual) schedule. This is based on the recognition that both processes provide guidance to communities, regions and the state as to appropriate levels and distribution of health care resources. Integration of these procedures would be designed to create a simpler process and gain greater public input into resource planning.

6. **Continue the certificate of need program in its current form but consider transferring responsibility for it to the Health Care Authority.**

SB 285 mandated the Authority to consider whether any changes are called for in Montana's certificate of need program under a health care reform scenario. The Authority carried out this task and submitted its report to the legislature and governor on December 1, 1994. In that report, the Authority recommends that the current certificate of need process be retained, but recognized the need for additional program resources in order to more effectively administer the statutory requirements.

The Authority also recommended that current non-reviewable entities should continue to be non-reviewable, but should notify regional planning boards and the Authority of capital

expenditures above statutory spending thresholds for inclusion in the resource management planning process.

Finally, the Authority also recommended that administration of the certificate of need program be transferred from the Department of Health and Environmental Sciences to the Authority along with comprehensive health planning since it is closely tied to those planning functions and coincides with similar cost containment activities of the Authority. With comprehensive health planning, the certificate of need process would then function closely with the health care resource management planning process, combining several planning, reporting and data collection responsibilities.

7. Promote the development of consumer education mechanisms designed to increase individual responsibility for more efficient utilization of the health care system.

The Authority believes that a significant step in developing a solution to the problem of health care cost containment is to encourage and empower health care consumers to take greater responsibility for their health care purchasing decisions. There are two initial steps which can make a significant contribution to the accomplishment of this goal, including:

- Establish a uniform health care data base designed to develop and disseminate information to consumers regarding health care costs, utilization and outcomes. This information system should supply consumers with information on provider fees and charges and quality assessment efforts, including peer review ratings of providers, health plan ratings, accreditation or licensing surveys and specific health education programs.

- Encourage the development of third–party payer guidelines for health education services and encourage the inclusion of education and wellness components in health insurance benefit packages.

8. Encourage all hospitals to obtain independent rate review by joining the voluntary Montana Hospitals Rate Review System.

The Authority believes that the Montana Hospitals Rate Review System, a voluntary independent rate review system for hospitals in the state, can play a significant role in:

- the acquisition of information regarding Montana hospitals' rates, costs, capital expenditures and service expansion and utilization trends; and

- managing a reasonable cost containment process in our state.

Accordingly, the Authority has encouraged the Rate Review System to consider the following recommendations:

1. All hospitals in the state are strongly encouraged to become members of MHRRS. This is based upon the belief that all hospitals in the state should obtain an independent budget review on a periodic basis. Obviously, the MHRRS is in the best position to provide such review to Montana hospitals. Thus, the Authority believes that all Montana hospitals should enroll in the Rate Review System.

2. The Authority also believes that all members of the MHRRS should submit uniform data on a regular basis to the System. Without such uniformity, the information collected and evaluated by the MHRRS is not as meaningful or as useful as it could be.

3. Hospital reports submitted to the MHRRS should at a minimum contain information on rate levels, utilization levels and income levels for each individual member institution. Such information would be especially useful as an indicator of emerging trends in health care system costs.

4. The feasibility of incorporating the MHRRS' data into the unified data base required by SB 285 should be seriously explored.

5. In consideration of the long term goals of improving the competitive nature of the health care market place and in providing consumers with better information regarding health care costs. the MHRRS should consider ways of opening at least part of its meetings to the public and regularly publishing hospital cost information in a uniform format easily understood by consumers.

9. Implement a simplified billing approach for health care providers in Montana.

SB 285 allows the Commissioner of Insurance to adopt a uniform health insurance claim form with uniform standards and procedures for filing claims. The objective of a simplified billing process is to reduce administrative costs in the insurance and health care provider industries. Reduced costs can be achieved when payers use a common claim form and an electronic claims clearinghouse. Ultimately, the health care consumer should benefit through a simplified and more efficient process where payers and providers are communicating with the same claims forms and, most importantly, an impact on the rate of health care price inflation. The Authority supports the efforts of the Insurance Commissioner to implement a common claim form and, eventually, an electronic claims clearinghouse as important mechanisms for reducing administrative costs in the health care industry. It believes, however, that a common claim form, to be truly effective in reducing administrative costs, should be applied to all medical insurance programs and carriers, including Medicaid and Workers' Compensation.

10. Continue to monitor and evaluate medical malpractice and tort reform measures.

SB 285 charged the Authority with examining the issue of defensive medicine and to develop appropriate recommendations to reduce its cost. Defensive medicine occurs when health care providers order tests, procedures, or visits or when they avoid high risk patients or procedures primarily (but not necessarily solely) because of concerns about malpractice litigation.

As this definition indicates, the practice of defensive medicine can have both access and cost implications. With respect to the cost impact of defensive medicine, the Authority reviewed information placing the nationwide cost of defensive medicine in 1989 as high as $15.1 billion. However, methodological problems make it extremely difficult to accurately calculate the true costs of defensive medicine. A recent study by the U.S. Office of Technology Assessment concludes that the evidence implies that defensive medicine is "neither a trivial nor a major contributor to health care costs".

Specifically, the statute required the Authority to examine the possible effects of both practice protocols and tort reform on controlling the practice of defensive medicine and the costs associated with it.

Practice protocols. The Authority commissioned a study of the potential role that practice guidelines could play in reducing the incidence of defensive medicine. That study examined initiatives underway in several states that provide for special treatment of certain practice parameters when they are introduced as evidence into medical malpractice cases. While the Authority recognized the potential role that practice protocols could play in reducing the practice of defensive medicine, it also recognized that the development of guidelines can be quite expensive and that the initiatives underway in other states are too new to be evaluated. For these reasons, the Authority deferred making a recommendation concerning the formal introduction of practice protocols as evidence in medical malpractice cases until such time as information evaluating the impact of such initiatives in other states is available. Representatives from both the Montana Trial Lawyers Association and the Montana Medical Association provided comments to the Authority that were consistent with this position.

Tort reform. SB 285 also charged the Authority with studying tort reform measures related to medical malpractice, including: (1) limitations on the amount of noneconomic damages; (2) mandated periodic payments of future damages; and (3) reverse sliding scale limits on contingency fees. The Authority was also authorized to consider changes in the Montana Medical Legal Panel Act.

Before undertaking its own in–depth study of these matters, the Authority considered it appropriate to closely examine the work and review the recommendations of the legislature's Joint Interim Subcommittee on Insurance Issues. The subcommittee, charged by the 1993 legislature with studying medical malpractice problems and possible tort reform measures, adopted two recommendations after a thorough examination of these issues: (1) a measure which would clarify "applicable statutes of limitations related to medical malpractice claims"; and (2) revisions to the Medical Legal Panel Act requiring that "upon request, the panel articulate the reasoning and basis for a decision"; and "requiring mandatory, nonbinding mediation for an affirmative panel decision".

After consideration of the above information and material, the Authority has chosen not to take a position on tort reform.

Health Care Delivery System and Infrastructure

1. **The importance of a unified health care information data base.** The Authority considers the establishment of the unified health care information data base provided for in SB 285 to be one of the highest priority projects. It will provide essential, accurate, timely and Montana–specific information about the level and nature of health care spending, utilization and quality of care to consumers, providers and policy makers throughout the state. The Authority recognizes that the development of such a data base will be a significant and complex undertaking and believes that its development must begin as soon as possible if it is to be useful in helping to improve Montana's health care system problems and contribute to the Authority's proposed market-based sequential health care reform plan. **For these reasons, the Authority strongly recommends that adequate funds be made available to design and develop a unified health care information data base.**

2. **Strengthening the health care delivery system.** The Authority recognizes that to truly achieve the goal of providing all Montanans with access to needed care, efforts directed at providing universal coverage and controlling costs must be coupled with strategies to strengthen the infrastructure of the state's current health care delivery system and to address the resource shortages and maldistributions that exist within the state. To this end, the following developments should be encouraged within the state's delivery system:

   - Establishment of a comprehensive health care information data base. As noted above, the development of a statewide health care data base is critical to the long-term accomplishment of health care reform in Montana, even if reform is pursued incrementally. Without accurate and reliable data, efforts to contain costs and reduce utilization will not be successful.

   - Increased linkages among rural providers as well as between rural providers and specialty care systems;

   - Expansion of managed care activities within the state, as long as standards are established to ensure that such managed care systems provide quality care and do not inappropriately constrain individuals' access to needed services or providers' ability to deliver such services;

- Promotion of competition among health plans in areas of the state where this is feasible;

- Reorientation, conversion, or possibly even the closure of underutilized facilities, as long as such changes are made with local and regional input and are made in the context of a coordinated health resources management plan that identifies the implications of such changes on the long–run objectives of the system; and

- Expanded and more efficient use of mid–level practitioners, as long as such efforts are undertaken in the context of a broader strategy to coordinate development of all levels of health care delivery systems.

3. **Regulatory reform.** The current approach to regulation of the health care system by both federal and state governments can serve as an impediment to the effective and efficient operation of the system. Often confusing and contradictory requirements enforced by multiple agencies at both the federal and state levels can and do result in unnecessary cost increases and inefficient operations by both individual and institutional providers. The Authority therefore believes that reform of the regulatory system is essential. These reforms should entail consolidation of regulatory functions wherever possible into a single state agency and the identification and elimination of confusing and contradictory regulations.

4. **Public health system improvements.** Health care reform must bring about important changes in our health care financing and delivery system in order to improve the affordability and availability of needed health care services. However, changes made to the health care financing and delivery system alone will not be sufficient to maintain and improve the health status of the state's population. Indeed, many of the improvements in health status that have been achieved over the years have come as the result of public health improvements, such as the provision of safe drinking water, the control of communicable diseases, etc. To ensure that the health of all Montanans improves in future years, it is essential that medical care system reform be coupled with a commitment to maintain and strengthen public health–oriented efforts.

For these reasons, the Authority supports the inclusion of and funding for a strong public health system component as an integral part of market–based sequential health reform. The following core public health functions and activities must be included as part of any health care reform strategy adopted by the state:

- Health assessment;
- Policy development;
- Health education and promotion;
- Outreach;
- Quality assurance; and
- Outcome monitoring.

It is within this context that the Authority recommends support for the proposal developed by the Montana Committee on Improving Public Health to strengthen Montana's public health system. The two–fold initiative first offers to assist in the better use of health status data for local and regional health planning purposes. Second, it proposes to create a process to examine, standardize and bolster the public health infrastructure across the state. The Authority believes that the cost of $219,000 for this effort would be money well spent.

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